EXHIBIT 21
DATE 1-10-07
HB 2

Supporting

Critical Funding for Community Mental Health Services

Central Service Area Authority (CSAA)

Eastern Service Area Authority (ESAA)

Western Service Area Authority (WSAA)

Mental Health Oversight Advisory Council (MHOAC)

Montana Association of Counties (MACo)

Montana County Attorneys Association

Sheriffs and Peace Officers Association

Montana Mental Health Association (MMHA)

National Alliance on Mental Illness, NAMI-Montana

Gallatin County Mental Health Local Advisory Council

Montana Eighteenth Judicial District Court

Park County Mental Health Local Advisory Council

Great Falls Local Advisory Council

Helena Local Advisory Council

Kalispell Local Advisory Council

Eastern Montana Community Mental Health Center

Jefferson County

Lewis and Clark County

Billings Local Advisory Council

Central Service Area Authority
745 Mary Road
Bozeman, Montana 59718

July 31, 2006

Joyce De Cunzo, Administrator
Addictive and Mental Disorders Division
Department of Public Health and Human Services
P. O. Box 202905
Helena, MT 59620-2905

RE: Critical Funding for Community Mental Health Services

Dear Joyce,

Positive change is happening in Montana as the Addictive and Mental Disorders Division (**AMDD**) and Service Area Authorities (**SAAs**) work together to provide for the delivery of quality care for adults who are seriously mentally ill, for those who are addicted to alcohol or substances, and for those, who because of untreated severe mental illness, carry the additional burden of addiction. But change, even positive change, happens slowly and is often painful. The Service Area Authorities take very seriously the charge given to them by the Legislature to collaborate with **AMDD** to plan, implement, and evaluate mental heath services, and to promote a consumer and family driven system of care.

Demographics in Montana are changing at a rapid pace. Services for the severely mentally ill are often no longer adequate or appropriate for a changed and growing population. As community services fail to keep pace with change, the system experiences the inevitable growth in more expensive care outside of the community. The system is constantly adjusting to the need for change and at the same time resisting it. Some Montanans receive adequate funding through Medicare, Medicaid, VA Health Care, or private insurance; however, a large percentage of Montanans remain uninsured and un-served. We face daunting challenges as we work together to provide services to Montanans needing care for mental illness and addiction.

How do we collaborate to manage the system so that we can provide for the basic care necessary to help the mentally ill to recovery? We agree on the broad plan: 1) Identify

very ill, and only at the **MSH**. This is a vivid example supporting the claim of advocates for the mentally ill that adequately funded community services for uninsured persons with mental illness reduces the need for higher levels of more expensive care outside the local community. The three Service Area Authorities agree and recommends to **AMDD** that the income requirement for **MHSP** eligibility be raised to 200% of the Federal Poverty level.

There are very serious unintended consequences of under-funding the **MHSP**. Poor Montanans who are underserved or un-served often are diverted to the criminal justice system, cannot remain gainfully employed, self-medicate with illegal substances and alcohol, suffer family breakup, experience social alienation, experience increased physical illnesses, present to hospital emergency rooms in mental health crisis in disproportionate numbers, contribute to an increasing census at the Montana State Hospital, become homeless, finally in desperation may commit suicide. Montana has the 2nd highest rate in the nation for suicide. The cost in human suffering is very high but difficult to quantify. If we were able to quantify the extended and indirect cost of under-funding this program and divert that amount as a credit to **MHSP** that amount would very likely be sufficient to fully fund an adequate **MHSP** for more people. Studies show that appropriate care and supportive services offered in the community before a crisis develops is more humane and cost effective than the cost of hospitalization.

There are less obvious, but nonetheless serious consequences of under-funding the public mental health care for the poor. One of the most notable consequences is that most of the care for the uninsured or underinsured population is charity care provided by hospitals, many of which are small struggling hospitals in rural communities, and Licensed Community Mental Health Centers **(CMHCs).** The charity care is provided by **CMHCs** in under-funded contracts to deliver services to **MHSP** patients. At one time, compensation for the same services delivered under **Medicaid** and **MHSP** was identical. After the demise of Managed Care, **MHSP** was cut 50% and there have been no subsequent increases. **CMHCs** are non-profit corporations that operate on very small margins used to build and maintain infrastructure necessary to provide quality services. **CMHCs** are being squeezed past their ability to absorb the cost of charity and unfunded **MHSP** care, and thus their ability to create new beds or services in the community disappears as operating capital becomes exhausted. For example, last year **CMHCs** provided $11,600,000 in mental health services to **MHSP** clients but were only reimbursed $3,433,146. The cost of un-reimbursed services is $8,166,854. For every $1.00 of **MHSP** services provided by **CMHCs**, $0.30 was reimbursed and $0.70 was charity taken from **CMHCs** current assets, including staff. The result is that **CMHCs** plan to cut costs far beyond sound business practice. For example some of the reductions presently budgeted include reductions in staff, no salary increases, reduced benefits, no stipends for continuing education credits, reduced accumulation of capital for repair and replacement of physical plant, no capital spending for new programs and facilities, and reduced services for patients on **MHSP**. It is difficult to recruit and retain motivated staff at current compensation levels. Although most **CMHCs** staff is dedicated and generous, it is too much to expect that they should continue to carry this burden while trying to support themselves and their families

In summary, the **CSAA** urges the Department of Public Health and Human Resources and **AMDD** to support increased funding for **MHSP** and to restore the original joint Service Area Proposal to provide **72 Hour Presumptive Eligibility** for crisis services. I attach the prioritized needs previously submitted to **AMDD** for reference. Kindly consider these recommendations seriously as you go forward with the EPP.

Sincerely,

Thomas A. Peluso, President
Central Service Area Authority

Tom Bartlett, President
Western Service Area Authority

Alice Hougardy, President
Eastern Service Area Authority

Cc: **Joan Miles, Director, DPHHS**

John Chappius, Deputy Director, DPHHS

Anna Whiting Sorrell, Policy Advisor to Governor Brian A. Schweitzer

Trudi Schmidt, Presiding Officer, SJ 41 Interim Committee on Children & Families